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AUTHOR Schwartz, Sandra R.; And Others
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ABSTRACT

A study was designed to develop an empathy training program for health professionals that would (1) improve selected predictive, behavioral, and achieved empathetic communication skills for a sample group of registered nurses; (2) evaluate the effectiveness of the training program in attaining its stated goals; and (3) develop a program that could be utilized by the hospital for further in-house education. The program was designed with an eight-hour format, divided into two four-hour sessions, each including lecture, discussion, and group activities. Theoretical background material was included in order to make the participants aware of the impact of empathy on health care and on the quality of the nurse/patient relationship. Lecture and discussion focused on the unique aspects of the hospital environment and its effect on the patient as manifested in good and bad patient behaviors. The discussion of empathy as a therapeutic tool focused on the communication skills related to the predictive, behavioral, and achieved phases on a multistage approach. An evaluation of the program was based on participants' response to two scales: the Allied Health Professional Empathy Discrimination Index, and a forced choice instrument. Results supported the following program outcomes: an increased awareness among program participants of the importance of empathy in health care, increased knowledge of the empathy process, and increased empathic behavioral skills. (HOD)

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# INTERPERSONAL EMPATHY:

# A TRAINING PROGRAM FOR HEALTH CARE PROFESSIONALS

by

Sandra R. Schwartz,M.A.
Susan E. Kogler Hill, Ph.D.
Richard A. Perloff, Ph.D.

from
Department of Communication
Cleveland State University
Cleveland, Ohio

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INTERPERSONAL EMPATHY:

A TRAINING PROGRAM FOR HEALTH CARE PROFESSIONALS


## Abstract

The present study represents an attempt to develop an empathy training program for health professionals which would improve specific communication skills and hopefully contribute to a more optimal communication environment. The goal was to develop an in-service empathy training program for nurses which would be based on current theories of interpersonal empathy and which would be evaluated to determine its educational effectiveness, thereby, creating a theoretical and data based approach to health education. This paper then explains the development of such a program and reports on the evaluation of the program's effectiveness.

Medicine today is increasingly embracing the holistic, humanistic approach which encompasses the total social, psychological, and physiological environment of the patient. Research has shown that deficiencies in the affective component of the health provider/patient relationship have far reaching effect on the total health and welfare of the patient. This is especially apparent in terms of mutual understanding of treatment expectations, attainment of therapy goals, patient control of health care, and a satisfactory level of mutual respect (Ben-Sira, 1976; Fuller & Quesada, 1973; Pellegrino, 1974; Recordon, 1972; Skipper, 1962; Walker, 1973).

Several studies have shown that patients tend to be more dissatisfied with the level of information given by their physician than with any other aspect of medical care (Bertakis, 1976; Korsch, Gozzi, & Francis, 1968; Reader, Pratt, & Mudd, 1957). Critical to the development of the affective relationship between health care provider and patient are adequate communication skills (Daly & Hulka, 1973). The failure to establish an acceptable pattern of communication has been found to be significantly related to noncompliance in adherence to drug regimen, adherence to prescribed diet,. return for scheduled appointments, and adherence to recommended changes in daily activity (Korsch, Gozzi, & Francis, 1968). Still other research has found that communication also affects

patient's satisfaction with medical care, incidence of malpractice litigations, failure to pay medical bills, and patient's response to and compliance with medical advice (Carroll, Schwartz, & Ludwig, 1980).

Empathy, an essential element of the optimal health communication environment, has been defined as the ability to effectively understand another and to communicate that understanding in a way that the other feels understood. Mansfield (1973) suggests that the level of empathic communication is in direct relationship to patient improvement regardless of specific diagnosis or prognosis. Empathic communication has been shown to improve the quality and outcome of health care for the aged (Cassata, 1976). The abortion patient experiences less physical discomfort and emotional distress as the result of empathic communication behaviors (Adler, 1979). Empathic behaviors increase the ability of the cancer and terminally ill patients to effectively cope with their diagnosis, treatment, and prognosis (Wortman & Dunkel-Schetter, 1979; Kastenbaum, 1979). DiMatteo (1979) concludes that in all health environments, when health professionals exhibit high levels of empathy, patients recover more quickly, comply more fully with therapy, and are more satisfied with their care.

The documented importance of empathic behavior in the helping relationship (Carkhuff, 1969; Barrett-Lennard, 1962; Kalisch, 1971), as well as the alarming evidence that health

professionals possess an extremely low level of empathy (Duff & Hollingshead, 1968; LaMonica, Carew, Winder, Haase, & Blanchard, 1976), suggests a need for training programs designed to improve the level of empathy among health professionals. Previous programs at both the academic and in-service levels have focused primarily on a single facet of empathy, adopting either a pragmatic or philosophical approach. This has often emphasized interviewing skills at the medical school level with a more specific skill orientation in nursing schools (Cassata, Conroe, & Clements, 1977; Pacoe, Naar, Guyett, & Wells, 1976; Ward & Stein, 1975). In many instances the focus is determined intuitively without specifying the theoretical basis for program content (Bachrach, 1976; Pearce, 1977).

The goal of the present study is to develop an in-service empathy training program for nurses which is based on current theories of interpersonal empathy and which will be evaluated to determine its educational effectiveness. The intent is to create a theoretical and data-based approach to health education. This program provides the potential to improve interpersonal empathy among nurses in a real health care setting. In addition, this paper presents an attempt to redress the imbalance in previous training programs and methods of evaluation by presenting a multi-faceted approach to empathy training which is strongly based on the multi-stage theory of empathy. The paper first seeks to outline the historical and theoretical perspectives of empathy through a brief literature review.

## APPROACHES TO EMPATHY RESEARCH

Initial approaches to the study of empathy focused on selected aspects of the empathy process and resulted in different operational definitions of empathy. Three major streams of empathy research emerge from the literature: preditive, behavioral and achieved. Each program of research is important to understanding the more current multi-stage approach to empathy.

### Predictive Approach

The predictive or cognitive approach to empathy originally proposed by Dymond (1949;1950) and advanced by Hobart and Fahlberg (1965) and Hogan (1969) is the role-taking approach to empathy. Empathy is the "imaginative transposing of oneself into the thinking, feeling and acting of another and so structuring the world as he does" (Dymond, 1949, p. 127). It is the ability to accurately predict the thoughts and feelings of another, i.e., to take on their role, even if the attitudes are different from one's own (Woodall & Hill, 1982). For example, I am empathic if I can take on your role and accurately know how you think and feel even if you are very different from me.

### Achieved Approach

The achieved or perceptual approach to empathy advanced by Barrett-Lennard (1962;1963) is an interactive-client centered approach. From this perspective, the thoughts and feelings of the other, while not becoming yours, need to be perceived

by the other as being understood (Hill, 1982). Instead of focusing on accurate understanding as in the predictive approach, here the focus is on whether the other person feels understood. For example, I am empathic if you think that I understand you, i.e., you perceive me as understanding you. I have achieved empathy because you believe that I understand.

Behavioral Approach

Truax (1961) advanced the behavioral approach to empathy which initially focused on verbal behaviors designed to communicate understanding. Here the focus is not on accurate understanding of the source or perceived understanding by the receiver, but on behaviors which promote understanding. Carkhuff (1969) emphasized the ability to communicate in a supportive way to the client. In other words, I am empathic if I can make appropriate understanding statements in response to you. Stetler (1977) expanded this primarily verbal approach by advocating a broad-based theoretical approach incorporating verbal, nonverbal, and vocal behavioral channels of communication.

Multi-Stage Approach

Problems inherent in these various approaches to empathy began to appear as researchers measured this elusive concept. Gage and Cronbach (1955) report that researchers often inadequately delineated what they intend to measure and/or fail

to outline the extent to which variables from different studies overlap. In addition, further studies have shown little or no relationship between the various measures of empathy (Northouse, 1981; Wallston & Weitz, 1975).

As a result, recent conceptualizations of empathy (Hill, 1980; Northouse, 1981; Barrett-Lennard, 1981) have suggested that the process of empathy is more complex than earlier research has envisioned. These contemporary investigations advance a multi-stage view of interpersonal empathy which incorporates the three traditional approaches to empathy into one model.

Northouse (1981) suggested such a possible broad-based approach after investigating numerous empathy measures and finding little correlation among them. He suggested that perhaps each of these measures only taps a part of the entire process. Barrett-Lennard in psychology and Hill in communication have proposed very similar phase models of interpersonal empathy. The Barrett-Lennard model contains the following stages: empathic set, empathic resonation, expressed empathy, received empathy, and feedback. In his explanations these phases are very similar to the predictive, behavioral, and achieved empathy approaches discussed previously. He elaborates how these various phases of empathy occur sequentially and cyclically.

Hill (1980;1982), in a very similar conceptualization

of the phase construction of empathy describes the process as follows:

> Through interaction we gain information about others and begin to cognitively and emotionally understand them and how they differ from us (predictive empathy). We then attempt to convey that interpersonal understanding through verbal messages and nonverbal behavior (behavioral empathy). The receiver then processes these messages based on his expectations, stereotypes, and openness, and subsequently forms an impression of whether we are empathic (achieved, perceived empathy). The only way a source can know if they are perceived as empathic is through observation and feedback from the receiver (1982, p. 85).

Hill further elaborates on the communication skills necessary for the mastery of each of the phases of empathy. Since these skills have been used as a guideline for the construction of the present empathy training program, the Hill Model is included here.

THE PROCESS OF EMPATHY: A MODEL

| Stages of Empathy Process | Interpersonal Skills Needed |
|---|---|
| 1. Predictive Understanding | Role-taking ability, observing nonverbals, listening skills, predictive accuracy, self-disclosure, feedback, other directedness, non-defensiveness. |
| 2. Behavioral Understanding | Paraphrasing, supportive and understanding statements; nonverbal behaviors conveying warmth and understanding; congruency between nonverbal and verbal messages. |
| 3. Achieved Understanding | Perception checking, observation of nonverbal behaviors, receiving feedback. |

(Hill, 1982, p. 85)

## RESEARCH QUESTIONS

With the growing recognition of the importance of all aspects of empathy in medical/therapeutic relationships, an increasing number of communication skills training programs have been developed primarily for medical, psychiatric, and nursing students. Research has documented that nurses with low levels of empathy can dramatically increase their empathic abilities through short term training programs (Kalisch, 1971; LaMonica, Carew, Winder, Haase & Blanchard, 1976). In order to accomplish this, not only must the student develop an understanding of the quality of empathy, but he/she must acquire those skills which effectively translate this understanding into meaningful communication activity (Stetler, 1977).

The purpose of this study is to design a training program to (1)improve selected predictive, behavioral, and achieved empathic communication skills for a sample group of registered nurses, (2)evaluate the effectiveness of the training program in attaining its stated goals, and (3)develop an empathy training program which may be utilized by the hospital in further in-house education. This program has been designed with an eight hour format, divided into two, four-hour sessions including lecture, discussion and group activities.

The following research questions are proposed to determine the effects of this short term empathy training program:

1. Will registered nurses exposed to the empathy training program perform better on the predictive post-test when compared with the performance of a control group which has a similar demographic background?
2. Will registered nurses exposed to the empathy training program perform better on the behavioral post-test as compared with a)their performance on the pre-test, and b)the performance of a control group with a similar demographic background?

## METHODOLOGY

### Program Content

The present training program has been based on the interpersonal skills related to the multi-stages of empathy--predictive, behavioral, and achieved. Those methods and techniques which were utilized included lecture, discussion, and experiential activities.

Theoretical background material was included in order to make the participants aware of the impact of empathy on health care and on the quality of the nurse/patient relationship. Lecture and discussion focused on the unique aspects of the hospital environment and its effect on the patient as manifested in good and bad patient behaviors. The discussion included characteristics and causes of these

behaviors, as well as the consequences and their relationship to the communication environment of the patient. The discussion of empathy as a therapeutic tool focused on the communication skills related to the predictive, behavioral, and achieved phases on the multi-stage approach.

Predictive Stage. The program content concerning the predictive aspect of empathy emphasized the development of an understanding of how the other person thinks and feels in a health care situation. The method used to develop this skill included lecture as well as role-playing activities. The selected exercise required the participants to assume the roles of either health professionals or patients in a variety of health care interactions.

Listening was then discussed in terms of its importance in the development of an understanding of the other's feelings. The lecture/discussion included emphasis on the characteristics of empathic listening behaviors. This was accompanied by a paraphrasing exercise stressing the importance of listening with understanding as opposed to just hearing.

Behavioral Stage. The behavioral component of the program focused on responding skills. An exercise in response styles was utilized to improve the nurses' understanding of the differences between types of responses. The exercise emphasized the ability to give understanding responses, which have been identified as the response style most likely to communicate empathy (Johnson, 1972). The participants in this

exercise were assigned hypothetical health environment situations in which interpersonal interaction was required. To each of these, the group member was requested to respond in the indicated response style--supportive, hostile, probing, understanding, evaluative, or interpretative.

Achieved Stage. At the achieved level, the program focused on the development of skills to enable the participant to effectively send messages which would be perceived as empathic. The lecture material concentrated on the importance of nonverbal communication and particularly the congruence between the verbal and nonverbal dimensions. To increase the participants' awareness of others' nonverbal behaviors, to improve their accuracy in interpreting nonverbal communication, and to develop perception-checking skills, a perception-checking exercise was included.

Participants

The participants in this program were randomly selected from a list provided by the hospital. The hospital administration provided the names of all those registered nurses eligible for the program solely on the basis of time availability. The list included nurses from all shifts and from obstetrics, the coronary care unit, intensive care unit, and the emergency room. From the total population of 128 registered nurses, eighteen were randomly selected to participate in the program. These nurses were told that they were participating in a pilot study of an in-service training program. Their decision to take part in the program was completely

voluntary in as much as some had to attending during hours when they were not ordinarily working, although they were reimbursed for their time.

All of the participants had frequent direct patient contact associated with their professional duties. The control group consisted of thirty-six individuals all of whom were employed in a health care setting. Although not all were hospital employees, all occupied positions involving extensive direct patient contact.

Evaluation Procedure

In an attempt to evaluate the success of the training program, the participants were administered two scales. The behavioral segment of the instrument, The Allied Health Professional Empathy Discrimination Index, was administered to the control group and as a pre-test to the experimental group. This forced choice instrument, developed by Payton, Beàle, & Meydrech (1975) requires a choice among five alternatives. The Index includes fifteen different health environment situations, each followed by five possible responses which the health professional might make.

Payton, et al. and others assessed the face validity of the instrument through field testing with Master's candidates in counselor education. Ninety-four percent of these students were successful in identifying the most empathic responses. The t-tests performed by these authors on the results of the pre- and post-tests indicated differences to exist at the .005 level of significance.

The second segment of the evaluation instrument was a multiple choice and true-false questionnaire developed by the author and based entirely and/or taken directly from the lecture and discussion material of the training program. This instrument was designed to assess the understanding and grasp of course content of the participants. The cognitive instrument was administered to the control group and as a post-test only to the experimental group. Because of the program specific nature of the content of this instrument, it was judged to be inappropriate for use as a pre-test. It was anticipated that program participants might become sensitized with two administrations of this short answer, objective measure (Campbell & Stanley, 1963). Therefore, only the behavioral instrument was administered to the experimental group as a pre-test.

EVALUATION DESIGN

| | Control Group | Experimental Group |
|---|---|---|
| Cognitive Instrument | One measurement only | Post-test only |
| Behavioral Instrument | One measurement only | Pre-Test Post-Test |

RESULTS

The reliability coefficients for the experimental group, as calculated with the Kuder-Richardson test, were as follows: cognitive post-test = .635; Allied Health Professions Empathy Discrimination Index pre-test = .913 and Allied Health

post-test = .900. The reliability coefficients for the control group, similarly calculated with the Kuder-Richardson test, were: cognitive instrument = .715; Allied Health Professions Empathy Discrimination Index = .932. Because these coefficients of reliability were sufficiently large, all test items were included in the analysis.

The first hypothesis stated that registered nurses exposed to the empathy training program would perform better on the cognitive post-test than a control group of comparable health care personnel. Improved performance is represented by an increase in scores which indicates, with the cognitive measurement, a greater understanding and recall of the lecture and discussion material presented in the training program. The experimental group showed a mean score of 30.72 with a standard deviation of 3.72. The scores of the control group on the cognitive instrument showed a mean score of 21.75 with a standard deviation of 5.06. A *t*-test for independent samples yielded highly significant results ($t(52) = 4.326$, $p < .0005$). This model accounts for an impressive amount of the variance ($R^2 = .46$). The significant *t*-test results indicate that the hypothesis was confirmed.

The second hypothesis predicted that(1) registered nurses exposed to the empathy training program would perform better on the behavioral post-test than a control group of comparable health care personnel, and (2)nurses' scores on

the behavioral post-test (Allied Health Professions Empathy Discrimination Index) would be higher than on the behavioral pre-test. Once again, improved performance is represented by an increase in scores indicating an improved ability to identify the most empathic response.

Analysis of the scores on the behavioral instrument showed that the mean of the control group was 4.83 with a standard deviation of 5.43. The behavioral instrument administered to the experimental group as a pre-test showed a mean of 8.22 with a standard deviation of 4.86; the experimental post-test results showed a mean of 12.00 with a standard deviation of 3.74.

The t-test for independent samples performed between the control and experimental post-test scores yielded highly significant results ($t(52) = 6.667$, $p < .0005$). Similar significant results were yielded by the t-test for related measures which was performed on the experimental pre- and post-tests ($t(52) = 4.754$, $p < 005$). This model also accounted for a substantial amount of variance ($R^2 = .303$). Thus, the significant t-tests indicated that all hypotheses were confirmed.

The evaluation of the results clearly shows that this theoretically based program did, indeed, reach the desired and projected goals. The data strongly supports the following program outcomes: (1)increased awareness, among program participants, of the importance of empathy in health care;

(2)increased knowledge of the empathy process from the four major perspectives--predictive, achieved, behavioral, and multi-stage; and (3)increased empathic behavioral skills. Thus, the results of this study have definitively shown that levels of conceptual knowledge of empathy and empathic behavioral skills can be significantly improved as the result of a short term training program in the health care setting.

## DISCUSSION

The major limitations of this study were imposed by the constraints inherent in the hospital environment. To minimize the disruption of the hospital routine and time demands on personnel, the control and experimental groups were drawn from different health care environments. Although both groups were of comparable age and work experience, the experimental group consistently scored higher on both pre- and post-tests. This may be explained by the cohesiveness created by a common work environment as well as the education orientation of this particular hospital. Despite the relatively small size of the experimental group, a good portion of the variance is explained by the regression model.

In addition, the ethical and practical constraints of the hospital environment made it impossible to utilize evaluation procedures involving personal interviews and/or observations. This would have required additional time and created an

undesirable interruption of professional activities. Furthermore, without a second evaluation after a time interval, there can be no conclusions regarding the long range sustained effects of the program.

The implications from this study suggest a possible direction for future research. While, in the past, researchers have assessed empathy by relying upon outside observers' subjective assessments, this study has been an attempt to develop and utilize a more reliable instrument which reduces the necessity for personal interpretations of the subjects' responses. In addition, this project has targeted a specific group, registered nurses, whom research has suggested should ideally possess a high level of empathic ability. A program has been developed which focuses on the particular empathic communication problems of nurses in the health care environment. As well as improving the empathic skills of the experimental group of nurses, as supported by the evaluation data, this program offers positive implications for the improvement of the interpersonal communication between health care provider and patient.

There remains a need to develop a more comprehensive scale to assess empathy as it is represented by its multi-stage components, as well as the implementation of such an instrument in a variety of health care environments. Refinement and development of these kinds of instruments are needed to enhance the growth of a body of knowledge applicable to the

health environment. As Northouse (1981, p. 15) has concluded, "Until a unified theory explaining the complex aspects of the empathic process is constructed and recognition is given to the diversity of empathy measures, the importance of the empirical findings concerning empathy remains unclear."

Given the research reported throughout the communication, psychology, and health care literature, there can be little doubt as to the importance of empathy in the facilitative and therapeutic relationship. This has far reaching implications in the training of health care personnel on both the academic and in-service levels. Nonetheless, the relationship of empathy to physician/nurse/patient interactions in the health care setting needs to be developed and expanded through future investigation.

An expanding body of health communication knowledge and insight can contribute to the development of communication skills training in medical and nursing schools. Similarly, health care institutions will become aware of the benefits to be derived from this training. Certainly, given the many implications empathy training has for improved diagnosis, treatment, prognosis, and recovery in diverse areas of health care, the implementation of empathy training programs such as this one becomes increasingly important.

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